STATE of IOWA
FMLA APPLICATION &
INTENT to RETURN to WORK

TO BE COMPLETED BY EMPLOYEE AND PERSONNEL ASSISTANT (please print or type)

Employee Name: _____

Department: _____

My spouse is employed by the State of Iowa (check one): ☐ Yes ☐ No
If yes, name the department and verify the number of FMLA hours used during fiscal year (if any): _____

TO BE COMPLETED BY EMPLOYEE (please print or type)

PERIOD OF FMLA LEAVE:

FROM: _____ **TO:** _____
(Date - must be included to process your application) *(Date - if known, indicate if unknown)*

CHECK THE APPROPRIATE BOX:

☐ **MEDICAL LEAVE** (Employee's serious health condition)
☐ **FAMILY LEAVE** (Family member's serious health condition, or the birth, adoption or foster placement of the employee's child)
☐ **QUALIFYING EXIGENCY LEAVE**
☐ **MILITARY CAREGIVER LEAVE**

Family Member/Servicemember Name: _____
Date of Birth: _____
Relationship: _____

Illness, Injury, or Condition: _____

Certification must be provided if requested on the Notice of Eligibility and Rights & Responsibilities form. Completion of this form is required in all cases. You may be required to supply further medical documentation. If FMLA leave is for your own serious health condition, you may be required to provide your employer with a written "fitness for duty" certification before you return to work.

I understand that during FMLA leave, I am required to pay my share of insurance premiums for which I am ordinarily responsible. If premiums are not paid within 30 calendar days of the coverage month, my insurance will be retroactively canceled.

I acknowledge that, if I do not return from FMLA leave for at least 30 calendar days due to reasons not provided for in the Family and Medical Leave Act, then FMLA does not apply to this period of leave and I am required to reimburse all insurance premiums paid by the State of Iowa during any periods of unpaid FMLA leave. If reimbursement is not made, insurance coverage will be canceled retroactively to the first of the month following exhaustion of paid leave.

I give my employer permission to obtain clarification from my health care provider (check one): ☐ Yes ☐ No

I intend to return to work (check one): ☐ Yes ☐ No ☐ Unknown

Your signature certifies that you have read and understand the information on this form.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Personnel Assistant Signature: _____ Date: _____

Personnel Assistant Telephone Number: ( ) _____